

**TOWARDS MORE
APPROPRIATE HEALTH CARE
FOR TORONTO'S HOMELESS**

SUBMITTED TO

THE ONTARIO MINISTRY OF HOUSING, IYSH SECRETARIAT

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ACTION CONSULTING

1 INTRODUCTION

The major purposes of this study are (i) to identify the specific health needs of the homeless in Toronto and (ii) to identify the most appropriate health delivery systems.

There are some obvious reasons for concern over the health care needs of the homeless, two of the most obvious that have become a motivating force for this study are: (i) the homeless have considerable difficulty in gaining access to the traditional health care providers and (ii) the materially deprived lifestyle of the homeless makes them particularly vulnerable to health problems. Thus the population that runs the greatest health risks of any in modern urban society also has the greatest difficulty in gaining access to traditional health care facilities.

ACCESS

Difficulty of access is not peculiar to the homeless. A recent study carried out under the auspices of the Social Planning Council of Metropolitan Toronto (Doyle and Visano, 1987) documents the difficulty that members of 'diverse cultural and racial groups' have in gaining access to health and social services in Metropolitan Toronto. In this case difficulties of language, discrimination and cultural perceptions build barriers that prevent members of these groups from enjoying the same access to services as that experienced by 'mainstream Canadians'. We would submit that the barriers to health services experienced by the homeless are just as great if not greater than those experienced by members of 'diverse cultural and racial groups'.

Homeless people are discriminated against in many subtle and not so subtle ways by those who manage and run traditional health delivery services. They may be considered unclean, unreliable, inferior, dangerous, unworthy. They may be feared or loathed.

Such views may be held at the conscious or unconscious level. More benignly, but just as dangerously, deliverers of health care may view the homeless in patronizing or paternalistic ways and may dispense health care in a way that follows a 'charity model', rather than accepting that as citizens they have the right to health care as does anyone else.

Unconscious barriers raised by such subtelties as language use differences can make access difficult and unnerving for the homeless. Basil Bernstein (1971) has demonstrated how different social classes use language in different ways. Working class people tend to use what Bernstein refers to as restricted language codes wherein anecdotes are used to pass on messages and make sense out of life. By contrast middle class people make greater use of conceptual and theoretical images in their language. In a typical interchange between a provider of health services and a homeless person we thus have something of a language barrier that is likely to be threatening and puzzling to the homeless person and that confirms the 'superiority' of the health provider. It is such subtle barriers as this that make the encounter with health care providers a negative experience for the homeless.

LIFESTYLE

The day to day life of the homeless person is one in which constant threats to health are experienced. He/she may live in a crowded hostel environment where there is constant danger of infection from communicable diseases. He/she may live outside where, particularly in a climate as harsh as Toronto's, there is a likelihood of illness through exposure. Access to decent food is limited because food costs money and most homeless people have little of it. Therefore, it is unlikely that the homeless person will have a wholesome diet. There are often threats of and actual experiences of violence on the street and in the hostels and these experiences can lead to serious bodily damage.

Thus to be homeless is to live in the most unhealthy of urban environments and to have minimal access to those services that are set up to 'repair' those damaged by the environment.

Poverty itself is, of course, a threat to health. The City of Toronto's 1983 study (Miller and Edwardh, 1983) The Unequal Society documented the effects of poverty on health for Toronto residents. The homeless are the poorest of the poor.

In 1987 the Toronto Union of Unemployed Workers sponsored an enquiry into the effects of homelessness on health. Not surprisingly, the inquiry found that homeless people suffer far more than the general population from conditions related to exposure, from nutritional disorders, from tuberculosis, from skin problems and from infectious diseases. Sleep deprivation caused by long-term residence in hostels for the homeless was also seen as a major problem leading to a reduced ability to cope with an already tremendously difficult situation.

STREET HEALTH

Of particular importance to the present study is the health care delivery service known as Street Health. Action Consulting has been involved with Street Health since the initial development of the idea in 1985. The idea came out of discussions with homeless people in drop-in centres in down town Toronto. It was because of direct involvement with Street Health that Action Consulting decided to conduct the present research study.

Street Health first opened in January, 1986 as an adjunct to the Friendship Centre - a drop-in centre for the homeless located in the All Saints Church complex at the corner of Dundas Street East and Sherbourne Street in downtown Toronto.

Street Health provides basic health care services to the homeless several hours each week in a non-institutional setting. The health care service is provided by public health nurses on a volunteer basis. Street Health is managed by a community board that comprises community residents and homeless people.

Street Health sees the homeless as a distinct special interest group with particular health needs. It works to provide a health care service that will cater to those needs in an appropriate, i.e. non-institutional, non-threatening, easily accessible; setting.

For those at Street Health it is important to accept and fully understand the lifestyles and difficulties of homelessness and to understand the needs of the homeless as they articulate them. Thus there is a rejection of 'professional only' definitions of the situation. There is a recognition that many of the homeless hold distrustful attitudes toward health care delivers in the traditional system; that there is considerable difficulty for many of the homeless in understanding directions given to them by health care delivers and that the lack of OHIP coverage and money presents barriers to the use of that system.

An important tenet of the Street Health approach is that equal access to health care is a right to all in Ontario.

The present study aims to provide further evidence of the special health care needs of the homeless and to identify the most appropriate health care delivery systems to provide for those needs. It will do this through a discussion of the results of an interview survey with homeless people, with health care deliverers, and with staff of non-governmental organizations that provide health care services in the Third World.

2. DATA COLLECTION METHODS

The bulk of the data for the study was collected through structured interviews with the homeless and health care agency personnel. Several unstructured interviews were carried out with personnel from non-governmental organizations providing health care services in the Third World. A literature review of Third World models was also carried out. Given the exploratory nature of the study there was no attempt to draw statistically random samples from the populations of homeless or service deliverers.

However, it is felt that those interviewed represented a good cross section of the relevant populations, and that they approximate a stratified random sample.

HOMELESS INTERVIEWS

Structured interviews were carried out with 60 homeless persons in informal settings such as drop-in centres, doughnut shops, hostels, and on the street. There was an attempt to make the sample as representative as possible by interviewing a mix of males and females and by interviewing homeless people of a wide age range. The interviews took an average of an hour each. Since Action Consulting is familiar with and well-known to the homeless population, it is felt that the respondents were comfortable during the interview and that they answered the questions honestly.

HEALTH CARE PERSONNEL INTERVIEWS

Structured interviews were administered to 32 health care personnel in eight different health care delivery locations. Again the interviews took an average of an hour each. In most cases the interviews were carried out directly by Action Consulting but in several cases intermediaries known to both Action Consulting and the interviewee were used.

THIRD WORLD COMPARISONS

Informal discussions were held with personnel of non-governmental agencies dealing with health service delivery in third world countries. In addition literature was acquired on some of these models. The discussions and literature have been used to look at some of the third world alternatives in this study.

In the following section the results of the interviews will be presented.

3. RESULTS

3.1 Interviews with the Homeless

As stated previously, 60 homeless people were interviewed in a variety of informal settings. It was felt that by conducting the interviews on the 'turf' of the homeless that the respondents would feel comfortable and unthreatened and, therefore, able to answer the questions in a forthright and honest way.

CHARACTERISTICS OF THE SAMPLE

Sex

There were 26 (43%) females and 34 (57%) males.

Age

Ages were estimated in six categories as follows: less than 20; 21-30; 31-40; 41-50; 51-60; over 60. Proportions falling into each of the categories were as shown in Table 3.1.

TABLE 3.1

AGE CATEGORIES - HOMELESS RESPONDENTS

<u>Category</u>	<u>Number</u>	<u>Percent</u>
Less than 20	1	2
21-30	19	31
31-40	25	41
41-50	10	17
51-60	4	7
Over 60	1	2

By age group the sample is concentrated in the age range between 21 and 40 years, this group accounting for 44 or 72 percent of those interviewed. This compares closely with the age range of hostel residents in Toronto as reported in the Metropolitan Toronto study No Place to Go, published in 1983. This latter study estimated that 56 percent of the hostel population in Toronto was between the ages of 18 and 44.

Mobility

In order to get a sense of how geographically mobile respondents are we asked how long they had lived in Toronto. For most respondents this was 'all my life'. The actual number of years spent in Toronto varied widely, ranging from 2 months to 55 years. The average length of time spent in Toronto was 20.25 years.

Respondents were also asked if they considered Toronto to be their home town. By far the majority of respondents, 48 (80%) felt that Toronto is their home town, the remaining 12 (20%) gave other locations as their home town. Of these five (8%) named another Ontario town as home; two (3%) named a town in another Canadian province; one (2%) named a city in the United States and four (7%) named towns in overseas countries.

Type of Housing

Respondents were asked what kind of housing they were currently living in, the results are tabulated in Table 3.2.

TABLE 3.2
TYPE OF HOUSING¹

<u>Type</u>	<u>Number</u>	<u>Percent</u>
Hostel	24	40
Apartment	14	23
Room	13	22
House	4	7
Outdoors	3	5
Group home	2	3

In sum, the major points that stand out about the characteristics of the sample of homeless people interviewed are: there are slightly more males than females (57% compared to 43%); the age concentration is in the 21 to 40 years range (72%) (Young to early middle age?); there is a very low level of geographic mobility, most respondents having lived in Toronto for most of their lives; amongst them hostels, apartments and rooms account for the housing situation for 85% of the sample, with hostels alone accounting for the largest proportion - 40%.

We feel that the characteristics of the sample are similar to those for the homeless population as a whole and that, therefore, their views and experiences regarding health conditions and the delivery of health services are likely to be representative of the homeless population as a whole.

¹ It should be noted that, even though some of the respondents might, at first glance, appear not to be 'homeless', i.e. they may currently be living in a house or an apartment, such people are deemed to be homeless in that they have spent most of the last several years in temporary housing situations such as hostels or on the streets. All four respondents who were living in houses at the time of interview were living with a relative - e.g. an aging parent. But in all four cases only short periods of their recent lives had been spent in such situations and three of the four talked of leaving very soon because of what they saw as untenable situations.

ADEQUACY OF HEALTH SERVICES

Respondents were asked if they feel the level of health care services in Toronto is adequate. Exactly 50% said that they felt the level was adequate and the other 50% answered "no". These latter 30 respondents were then asked why they felt the services are inadequate. The 30 respondents who were concerned with the adequacy of services gave 16 different reasons why they felt the services are inadequate. This information is summarized in Table 3.3. (Note that respondents tend to give more than one response so that number of responses will normally be greater than number of respondents.)

TABLE 3.3

REASONS WHY SERVICES CONSIDERED INADEQUATE

<u>Reason</u>	<u>Number of Responses</u>
Have to wait too long to get service	19
Doctors and nurses don't seem to care	6
Services inaccessible to low income people	4
Inadequate dental care	4
No OHIP	2
Ambulance service too slow and inadequate	2
They dope you up without listening to you	2
Poor services for women with children	1

The thing that leaps out from Table 3.3 is the marked concern with the amount of time required before one is able to get health care service. Respondents frequently spoke of very long waits in emergency departments of downtown hospitals. Often they would get discouraged and leave without receiving some kind of treatment.

USE OF HEALTH CARE SERVICES

Homeless respondents were asked if they had ever used health care services in Toronto. To this question all respondents answered

"yes". They were then asked what kinds of health services they had used. Hospitals had been used by 56 respondents, clinics by 43 respondents (16 of whom had used Street Health), and doctors were mentioned by 18 respondents.

Hospital experiences were then focussed in on and respondents were asked to name hospitals they had been to and for what condition. Table 3.4 lists hospitals used by number of visits named by the respondents.

TABLE 3.4

HOSPITAL USE - NUMBER OF VISITS

<u>Hospital</u>	<u>Number of Visits</u>
St. Michael's	40
Wellesley	15
Toronto General	9
Women's College	6
Toronto East General	6
St. Joseph's	5
North York General	4
Mount Sinai	4
Doctors' Hospital	3
Queen Street Mental Health Centre	3
Clarke Institute	3
Hospital for Sick Children	3
Scarborough General	2
Queensway General	1
Northwestern General	1
Humber Memorial	1

The thing that stands out most in Table 3.4 is the heavy use of St. Michael's when compared to the use of all other hospitals. The only other hospital that a high proportion of respondents had used is Wellesley which shows less than half the number of visits as St. Michael's.

Respondents were then asked what the reasons for these visits were and these are shown in Table 3.5.

TABLE 3.5

REASONS FOR HOSPITAL VISITS

<u>Hospital</u>	<u>Reasons</u>
St. Michael's	pneumonia, childbirth, burns, tests, heart attack, headaches, injections, addiction, epilepsy, broken arm, constipation, prostate glands, seizure, dental, back, fight injuries, abscess removal, ear flush, heart operation, kidney operation, cuts, drug overdose, infection, psychiatric, leg injury, appendectomy
Wellesley	tests, injuries, ulcers, diarrhoea, epilepsy, broken arm, fight injuries, back, drug overdose, burns, dietician, colds, kidney operation
Toronto General	gunshot wound, a place to go, group therapy, epilepsy, operation, hand injury, brain scan, dental, blood test
Women's College	tests, childbirth, foot infections
Toronto East Gen.	childbirth, leg injury, arthritis, psychiatric
St. Joseph's	epilepsy, childbirth, fever, eye operation
North York Gen.	psychiatric, nervous breakdown
Mount Sinai	childbirth, allergies, leg injury, ulcers
Doctors' Hospital	back, stomach
Queen St. MHC	psychiatric
Clarke Institute	addiction, psychiatric
Sick Children's	allergy, fever, epilepsy
Scarborough Gen.	knee injury, tonsils
Queensway Gen.	burns
Northwestern Gen.	fever
Humber Memorial	fever

Again, St. Michael's is seen to be the 'hospital of first choice' for a considerable number of the respondents and for a wide range of conditions.

Predictably the hospitals that are most used are the ones that are closest to the downtown core where the majority of respondents spend most of their time. However, there are numerous hospitals in the downtown core and the question needs to be asked, "Why is it that St. Michael's is so heavily used when compared to other downtown alternatives such as the Toronto General Hospital".

PERCEPTIONS OF HOSPITALS

Respondents were next asked what it was they liked and disliked about the hospital health services with which they had dealt. The results are compiled in Table 3.6 and 3.7.

TABLE 3.6

WHAT RESPONDENTS LIKED ABOUT HOSPITAL SERVICES

<u>Feature liked</u>	<u>Number who mentioned it</u>
Friendly staff	9
Fast service	8
I'm treated well	7
Efficient service	6
Wide range of services available	4
Positive staff attitudes	3
Good food	3
Clean	3

The data in Table 3.6 may come as something of a surprise, given the previous critical comments made by the homeless respondents on the traditional health care delivery system. There are, however, several homeless people who speak positively of their experiences with Toronto hospitals. Table 3.7 shows that there

are also some that are very dissatisfied with the services they have received.

TABLE 3.7

WHAT RESPONDENTS DISLIKED ABOUT HOSPITAL SERVICES

<u>Feature</u>	<u>Number who mentioned it</u>
Have to wait too long	25
The staff just doesn't care	18
Generally poor service	5
Poor communication with doctors	5
Impolite staff	3
Have to leave too soon after an operation	3
Too institutional	1
Too public	1
Too many doctors	1

Waiting is the major problem raised by the homeless respondents. They recounted tales of waiting all night long in emergency waiting rooms and still leaving in the morning without being seen. There is a strong feeling that the staff of hospitals see them as second class citizens; people to be dismissed lightly as though they are of no significance. Hospital visits thus become times at which an already low level of self-esteem is even further battered. For many the way out of this is to avoid hospitals altogether.

Several respondents said that they couldn't understand what doctors were talking about and they were sure the doctors didn't really understand them. All they seemed to do was get rid of them as quickly as possible, with as little fuss as possible. Thus there is a tendency to be quick with prescriptions. Given that the homeless respondents were not usually in a position to pay for prescriptions, the whole experience had a been waste of time and a further exercise in frustration.

STREET HEALTH

As pointed out in the Introduction, the community-based health care delivery agency known as Street Health is of particular importance to the present study. This is primarily because Street Health was developed as an alternative to health care for the homeless through the more formal system of hospitals and non-community-based clinics. Consequently several questions in the interview were used to assess respondent's awareness of the existence of Street Health and their perceptions of the service if they were familiar with it.

Respondents were asked if they had heard of Street Health. Just over half the respondents (31) had heard of Street Health. Of these, 26 had actually used the service. Those who had used the service were then asked what it was they liked about the service. The responses are listed in Table 3.8.

TABLE 3.8

WHAT RESPONDENTS LIKED ABOUT STREET HEALTH

<u>Feature</u>	<u>Number who mentioned it</u>
It's friendly	14
No waiting	6
Easy to get to	6
Take time to find out what's wrong with you	4
Helpful	3
Informal atmosphere	2
Good referral service	3
They give direct answers	1
They're 'on our side'	1
Good follow up	1
A good board	1

The respondents that had used Street Health were then asked if they felt there were any problems with Street Health. Ten said they thought there were some problems associated with the service

the other 16 said they felt there were no particular problems with the agency. The nature of the problems identified by the ten respondents are shown in Table 3.9.

TABLE 3.9
PROBLEMS WITH STREET HEALTH

<u>Feature</u>	<u>Number that mentioned it</u>
Not sufficient funds	5
Staff is not paid and should be	2
More equipment is needed	2
The agency is not big enough	2
There should be more services	1

It is interesting to note that almost all these problems are not those of consumer displeasure with a service, as is often the case with problems mentioned regarding hospital service, they are the problems of survival that the agency itself faces.

Respondents who had used Street Health tended to identify with the service rather than see themselves in opposition to it.

The perception is that, should Street Health get more funding so that they could pay staff, purchase more equipment and expand in terms of size and the range of services offered, then it would provide an even better service to the homeless than is presently the case.

USE OF DOCTORS

Respondents were asked if they had a regular doctor, to which 37 (62%) answered "yes" and 23 (38%) answered "no". The 37 who had said they had a regular doctor were then asked if they were satisfied with that doctor, 30 of them (81%) said "yes," they were satisfied and the remaining seven (19%) said they were not. These seven were then asked what their reasons for dissatisfaction were and these answers are listed in Table 3.10.

TABLE 3.10
REASONS FOR DISSATISFACTION WITH REGULAR DOCTOR

<u>Reason</u>	<u>Number of times</u>
He never gives me a total physical	2
The physical exams are hurried	2
I have to wait too long to see her	1
Everything is "prescription"	1
Doesn't help me in getting benefits	1

Thus a fairly low level of dissatisfaction with service from a regular doctor was registered. The dissatisfactions that were raised again raise the problem of Dr.-patient communication.

HOUSING AND HEALTH

Earlier on in the discussion of homeless person interview responses we listed the type of housing currently lived in by the respondents. Respondents were asked if they found their current housing to be adequate. The responses to this question are listed in Table 3.11 by type of housing.

TABLE 3.11
RESPONDENTS' PERCEPTION OF CURRENT HOUSING

<u>Type of Housing</u>	<u>Number for whom housing</u>	
	<u>adequate</u>	<u>inadequate</u>
Hostel	9	15
Apartment	9	5
Room	4	9
House	4	0
Outdoors	1	2
Group home	1	1

Respondents living in hostels, rooms and the 'outdoors' showed the highest level of dissatisfaction with current housing situation. In all three cases those who found their housing

inadequate was about double the number of those who found it adequate. The 32 respondents who found their housing inadequate were then asked in what ways they found it inadequate. The results are shown in Table 3.12.

TABLE 3.12

WHY CURRENT HOUSING IS INADEQUATE

<u>Type of housing</u>	<u>Reason inadequate and # giving reason</u>
Hostel	lack of privacy(11), dirty (3), too crowded(3), too regimented(3), poor maintenance(2), uncaring staff(2), too violent(1), too noisy(1), no storage(1), too many cockroaches(1)
Apartment	too expensive(2), poor maintenance(2), no privacy(2), too small(2), too stressful(2), (this respondent said that two tenants in the building had recently committed suicide) too many disputes with other tenants(1), Metro Housing not interested in tenants(1), too noisy(1)
Room	no cooking facilities(4), too many cockroaches(2), no washroom of own(3), (one respondent shared a washroom with 12 others!), no privacy(1), no refrigerator(1), no visitors(1), cold(1)
Outdoors	bad weather(2), no privacy(2), no cooking(1), no washrooms(1), no storage(1), too many police bothering you(1)
Group home	simply time to move on(1)

A wide range of inadequacies were listed by those who were dissatisfied with their current housing situation. Hostel residents expressed a great deal of concern about the lack of privacy and about the levels of cleanliness and maintenance. Hostel dwellers were also very concerned about the high level of regimentation that is imposed on them.

Apartment residents were concerned about high costs, poor maintenance and the stress brought about by dealing with tensions with other tenants. (It should be pointed out that several of the apartment residents live in shared apartments.)

Room dwellers were particularly concerned with the lack of cooking facilities and the lack of access to their own washroom facility. They were also concerned about cleanliness.

Predictably those living outdoors found bad weather to be a major problem. Lack of privacy also showed up as a major concern.

Respondents were asked if they felt their housing situation had a direct effect on their health. Forty six respondents (77%) answered "yes" and 14 (23%) answered "no". Those that answered "yes" were then asked to elaborate on what ways they felt their housing situation had direct effects on their health, the results are shown in Table 3.13.

TABLE 3.13

HOW CURRENT HOUSING SITUATION DIRECTLY AFFECTS HEALTH

<u>Housing type</u>	<u>How affects and # responding</u>
Hostel	stress caused by crowding and violence(9), unhygienic(4), frequent depressions(3), lack of sleep(1), staff give us hard time(1), poor nutrition(1), lack of heat(1)
Apartment	too hot in summer, too cold in winter(1), threat of being beaten up(1), not enough supports(1)
Room	no cooking(2) no stability(1), cockroaches(1), no stability(1), dirty (1)
Outdoors	poor nutrition(2), can't stay clean(1), can't brush teeth(1) can't change clothes(1), cold(1)

Hostel residents again emphasized stress related factors such as overcrowding and violence. Lack of hygiene was again seen as a problem with hostels. Few apartment residents made direct connections between their current housing situation and effects on their health. Both room dwellers and those who live outdoors found the lack of access to nutritious food constituted a major health problem.

MAJOR HEALTH PROBLEMS OF HOMELESSNESS

The interviews with homeless respondents were brought to a close with two questions, one that asked them to state what they felt were the main health problems facing homeless people, and finally they were asked how those problems might be most effectively dealt with. The answers to the first of these questions are shown in Table 3.14, those to the second question in Table 3.15.

TABLE 3.14
RESPONDENTS' VIEWS OF THE MAIN HEALTH PROBLEMS

<u>Health problem</u>	<u>Number who mentioned it</u>
Psychiatric problems	23
Lice and other bugs	14
Unhygienic living conditions	11
Poor nutrition	9
Foot problems	9
Threats of and actual violence	8
Health problems kept quiet until too late	5
Skin problems	5
Alcohol related problems	5
Cuts and bruises	3
Lack of rest	3
Colds and fevers	3
Leg ulcers	2
Venereal diseases	2
Loneliness	2
Overcrowding	2
Drug related problems	2
Heart problems	2
Physical disabilities	1
Dental problems	1
Hearing problems	1
Back problems	1

As Table 3.14 indicates, a wide range of health problems was identified by the homeless respondents. Large numbers saw psychiatric problems and hygiene related problems as the major ones. To some extent cause and effect were mixed by the respondents so that some of the major causes such as lack of hygiene and proper nutrition could be seen as related to some of the major effects such as foot problems and psychiatric problems.

Table 3.15 lists the ways in which respondents felt that some of these health problems might be most effectively dealt with.

TABLE 3.15
DEALING WITH THE HEALTH PROBLEMS

<u>How to</u>	<u>Number of times mentioned</u>
More affordable housing	17
More Street Health-type services	14
Better access to existing health services	14
More money available to homeless	6
More work available to homeless	4
More access to nutritious and regular meals	4
More drop-ins	3
Preventive health care in hostels	3
More hostels	2
Cleaner hostels	2
More public education on homelessness	2

The 'how to' cover a range of suggestions from more and better housing to more public education. Most of them, however, are related to improving living conditions generally, e.g. more housing, more money, more work, or to improved access to health care services, e.g. more Street Health-type clinics, more access to existing services and preventive health care in hostels.

The foregoing section provides us with the data collected through the interviews with homeless respondents we will discuss these

data in further detail in Section 4, below. At this point we will present the data collected from the interviews with health care service personnel.

3.2 Interviews with Health Care Personnel

A total of 32 health care personnel were interviewed in various settings including emergency departments of large hospitals and in local clinics.

CHARACTERISTICS OF SAMPLE

We did not record sex and age of the health care respondents since we felt that such factors were irrelevant to the study. We did record occupations and the location at which the respondent worked. These are shown in Tables 3.16 and 3.17.

TABLE 3.16

HEALTH CARE PERSONNEL RESPONDENTS - OCCUPATION

<u>Occupation</u>	<u>Number</u>
Registered nurse	17
Social worker	4
Public health nurse	2
Youth worker	2
Psychiatrist	2
Psychologist	2
Physician (General Practitioner)	2
Clerk	1

Over half (53%) of the health care personnel respondents are registered nurses and the remaining 15 respondents come from a range of occupations, some being health care specialists such as the physicians and psychiatrists and others in non-health care occupations but working in health care facilities, e.g. youth workers and social workers. Table 3.17 gives the location at which the health care respondents work.

TABLE 3.17

WORK LOCATION OF HEALTH CARE PERSONNEL

<u>Location</u>	<u>Number</u>
Queen St. Mental Health Centre	13
Street Health	5
St. Michael's Hospital	3
Wellesley Hospital	3
Hospital for Sick Children	3
Toronto General Hospital	2
Inner City Youth	2
Toronto Dept. of Public Health Clinic	1

Respondents were interviewed at eight different health care work sites. The largest number, 13 (41%) are located at the Queen Street Mental Health Centre. A large number of interviewees were selected from that location for two reasons: (i) staff at the QSMHC is very familiar with homeless people; (ii) a wide range of people from different occupational groups was readily available for interviews. Occupations represented by the QSMHC respondents were: psychiatrist, psychologist, social worker, registered nurse, clerk and general practitioner.

LEVEL OF HEALTH PROBLEMS AMONG THE HOMELESS ACCORDING TO HEALTH CARE PERSONNEL RESPONDENTS

The health care respondents were asked what health problems do homeless people present with most often and they were asked to rank these as first, second and 3rd most often. The results are shown in Table 3.18.

TABLE 3.18

PROBLEMS THAT HOMELESS PEOPLE PRESENT WITH MOST OFTEN

<u>First Most and #</u>	<u>Second Most and #</u>	<u>Third Most and #</u>
Substance abuse(5)	Substance abuse(5)	Lice(4)
Psychiatric(4)	Respiratory(4)	Lacerations(4)
Schizophrenia(4)	Feet(3)	Malnutrition(2)
Feet(3)	Lice(2)	General neglect(2)
Colds(3)	Malnutrition(2)	Feet(1)
Malnutrition(2)	Leg ulcers(1)	Respiratory(1)
Respiratory(2)	Exposure(1)	Hypertension(1)
Skin problems(2)	Depression(1)	Depression(1)
Infections(2)	Infections(1)	Infections(1)
Pneumonia(1)	Flu(1)	Fever(1)
Aches and pains(1)	Pregnancy(1)	Psychiatric(1)
Seizures(1)	Psychiatric(1)	Abdominal pain(1)
Minor injuries(1)	Lacerations(1)	Urinary tract(1)
	Poor hygiene(1)	Poor hygiene(1)

Substance abuse (i.e. the detrimental use of drugs and/or alcohol) is seen as being a major reason for seeking help at the health services, with psychiatric, respiratory and foot problems also accounting for a substantial number of reasons for seeking health services. Infestations by lice and skin problems and malnutrition are also seen by many of the respondents as major precipitating factors. It is interesting to compare these conditions with the health conditions that the homeless consider to be the most frequent as shown in Table 3.14. We shall make some of these comparisons in Section 4. Discussion of Results, below.

OBSTACLES TO PROVIDING HEALTH SERVICES TO THE HOMELESS

We next asked the health care respondents if they felt there are problems in providing health care services to the homeless. To this question 29 (91%) answered "yes", they felt there are problems in providing health care services to the homeless. The remaining three (9%) felt that there are no problems in providing these services. (All three who answered in this way are located at the Wellesley Hospital.)

The 29 respondents who felt there were problems in provision were then asked what these problems are. Table 3.19 gives the responses to this question.

TABLE 3.19

PROBLEMS IDENTIFIED IN THE PROVISION OF HEALTH CARE

<u>Problem</u>	<u>Number of times mentioned</u>
Compliance to suggested treatment	8
Lack of full accessibility	7
Disorganization caused by lack of housing	7
Follow up almost impossible	6
No OHIP coverage	6
Inappropriate and bureaucratic services	6
Difficult to make appropriate referrals	3
No money available to fill prescriptions	3
No medical histories	2
Illiteracy problem	1
Lack of identification	1
Negative perception of the system	1
Negative attitude of the staff	1
No health care at hostels	1
Lack of support services	1

Obstacles to the provision of appropriate health care for the homeless, as seen from the perspective of health care providers

relate largely to the instability that comes with the homeless lifestyle. Not knowing where the next meal is coming from, where one will be sleeping tonight and how one can possibly scrape together the money to pay for a prescription means that it is difficult to comply to a course of treatment and to make it to future appointments.

Interestingly, few respondents felt that health care staff attitudes acted as an obstacle. It is useful to contrast this with the responses of homeless people given in Table 3.7 when they were asked to say what they disliked about hospital health services, a large number of respondents said that they felt staff attitudes toward them were a real problem. Again, these comparisons will be made and discussed below in Section 4.

To probe further into health care personnel views on the attitudes of staff in their agencies toward the homeless, we asked if staff at the particular location provides health care willingly to the homeless. 28 respondents (88%) answered "yes" and only four (12%) answered "no". Those who answered "no" were then asked what kinds of services are unwillingly provided. Only three responses were given in response to this question. These were: (i) "There is some unwillingness to accept 'NFA's'." (People with no fixed address.) (ii) "No one seems to be willing to provide assistance with the acquisition of housing." (iii) "There is little willingness to provide preventive care."

As another way of encouraging health care personnel to look at staff attitudes toward the homeless we made five negative statements about staff attitudes and asked respondents to say whether or not they agreed or disagreed with the statement on a five point scale. The results of this process are given in Table 3.20.

TABLE 3.20
RESPONSES TO NEGATIVE STATEMENTS ON
STAFF ATTITUDES TOWARD HOMELESS

<u>Statement</u>	Number who				
	<u>SA</u>	<u>A</u>	<u>N</u>	<u>D</u>	<u>SD</u> ²
Staff are impolite to the homeless	2	3	3	15	9
Staff are impatient with homeless	2	4	8	11	17
Staff are frightened of homeless	2	3	5	15	7
Staff unable to identify with h'less ³		12	6	5	6
Staff judgemental toward homeless	3	7	8	7	7

Again most of the respondents felt that staff in their agencies had a positive attitude toward their homeless clients. Very small numbers agreed or strongly agreed that staff are impolite, impatient or frightened of the homeless. However, almost half of the respondents, 15 (47%) either agreed or strongly agreed that staff are unable to identify with the homeless and 10 respondents (31%) either agreed or strongly agreed that staff are judgemental toward the homeless. Thus again, and not unexpectedly, we have a difference between the staff's self-perception and the way in which they are perceived by the homeless.

HEALTH PROBLEMS OF THE HOMELESS AS PERCEIVED BY HEALTH CARE PROVIDERS

Health care respondents were asked if they thought homeless people generally have greater health problems than the general population. To this question 26 (81%) answered "yes" and six (19%) answered "no". The 26 respondents who answered "yes" were then asked what they thought the major causes of these health

² SA=Strongly Agree; A=Agree; N=Neutral (i.e. no feeling one way or the other); D=Disagree; SD=Strongly Disagree.

problems are. The major causes identified are listed in Table 3.21.

TABLE 3.21
MAJOR CAUSES OF HEALTH PROBLEMS FOR THE HOMELESS AS
PERCEIVED BY HEALTH CARE RESPONDENTS

<u>Cause</u>	<u>Number who mentioned it</u>
Poor diet	16
Inadequate housing	7
Exposure	7
Poor hygiene	6
Substance abuse	4
Lack of compliance with treatment	4
No money	4
No support services	4
Lack of proper rest	3
Stress of life on the streets	2
Little self knowledge re health	3
Tobacco	2
Unstable lifestyle	2
Lack of follow up	2
Difficult to access health care	1
Impatience with health care system	1
Poor clothing	1
Low self esteem	1
Depression	1
Psychiatric problems	1
Violent encounters	1

It will be noted that there are some similarities between the responses given in Table 3.21 and those in Table 3.19. This is likely to be so to the extent that health care providers believe that health care services are a major component in the maintaining a relatively healthy population. Thus perceived causes such as lack of compliance with prescribed treatment and difficulty of access to health care will show up as having some

importance. However, what is probably more interesting is the fact that, again as in Table 3.19, the responses in Table 3.21 locate the causes in the 'wider environment' -e.g. in poor diets, inadequate housing, exposure and poor hygiene.

TOWARDS A MORE APPROPRIATE HEALTH CARE SYSTEM

The focus was turned back on to the health care delivery system by asking respondents how they felt the particular agency/hospital could provide more effective health care for the homeless. The responses are given in Table 3.22.

TABLE 3.22
WAYS IN WHICH THE RESPONDENT'S AGENCY/HOSPITAL MIGHT
PROVIDE MORE EFFECTIVE HEALTH CARE

<u>Way</u>	<u>Number who mentioned it</u>
More community satellite clinics	6
More staff to work with homeless	5
Longer and more flexible hours of service	4
Assistance with housing	3
Outreach programs (to hostels, etc.)	3
Staff education program on homeless	3
Provision of showers	2
24 hour social workers	2
More money for supplies	2
Increased advocacy role	2
Provision of subsidized medicine, free OHIP	2
Hire community workers from among homeless	1
Provide meals	1
Provide food vouchers	1
Improve discharge planning	1
Keep hostel list updated	1
Develop escort service	1

The overall thrust of the suggestions listed in Table 3.22 is toward a less institutional and bureaucratic way of delivering

the service. Outreach and advocacy, locating where the homeless live out their lives and the diminishing of material barriers to access, e.g. easy access to OHIP, all serve to give the suggestions a flavour of breaking down the barriers to access.

One possible way of making health care services more accessible to the homeless is by segregating them out from services that are provided for the rest of the public. We asked our health care respondents what they thought of the notion of segregated health services.

The respondents were almost evenly split on the question "Do you think there should be special segregated health care services for the homeless?" To the question, 17 (53%) answered "yes" , 14 (44%) answered "no" and one (3%) was "unsure".

The 17 respondents who felt there should be segregated health care services were then asked what form they felt such services should take. The results are shown in Table 3.23.

TABLE 3.23

THE FORM THAT SEGREGATED HEALTH CARE SERVICES SHOULD TAKE

<u>Form</u>	<u>Number that mentioned it</u>
Local, independent, community outlets	6
Satellite clinics, with close linkages	4
Clinics with ability to fill prescriptions	3
Hostel based health services	3
Mobile clinics	3

Those who feel there should be segregated services for the homeless tend to see such services as small- scale, community based, either community operated or linked to a larger facility, and located on the 'turf' of the homeless. Although most who advocated segregated facilities did so in terms of looking for a better way of serving the homeless, some did so in the interests

of the non-homeless who share public facilities with the homeless. For example, one of the respondents felt that the main argument for segregation was that integrated services presented a risk of lice infestation for the non-homeless.

At the end of the interview respondents were asked if they had anything more to add to what they had said. The following statements were made in response:

- * The homeless are unwilling to wait for services.
- * The homeless need understanding and rapid treatment.
- * Health care staff need to be more fully trained to understand the condition of homelessness.
- * The homeless should be seen as a special needs group.
- * Why is it that interns are not more fully trained in community health care?
- * The homeless require more training in self sufficiency.
- * More services should be provided where the homeless are.
- * Flexible services where no appointments are required should be set up.
- * Health care should be provided in hostels.
- * Hospital emergency departments are not equipped to cope with the homeless.

3.3 Third World Models

In his address to the International Year of Shelter for the Homeless Conference held in Ottawa in September 1987, John F.C. Turner suggested that third world countries may have a great deal to show developed countries in terms of handling their problems of homelessness. Mr. Turner has a long history of looking to the third world for low cost housing models that may have something to teach the developed world. The basic thesis behind the Turner model is that community-based approaches provide an alternative to private sector or public sector approaches. They are less expensive and more 'in touch' with local needs. Turner's books give examples of low income communities in third world countries

taking the provision of housing into their own hands, through the provision of their own 'sweat equity' and the bringing together of low cost materials.

In this study we are interested in housing only insofar as it impinges directly upon health, and, as much of the foregoing has shown, a major cause of health problems as perceived by the homeless themselves and the providers of health care is the lack of adequate housing. However, it is with the provision of health care services that we are most directly concerned here. And here again the John F.C. Turner suggestion to look to the Third World for models may be equally apropos.

Discussions with Ottawa-based personnel working with non-governmental agencies dealing with Third World issues and some reading of the literature on health care delivery in the Third World has convinced us that there are some useful models that might be transferred to urban Canada and that would help in the provision of appropriate health care systems for the homeless in urban Canada.

The non-professional, community-based approach to health care used in much of the Third World is of considerable interest to us. Detailed medical handbooks written in layperson's terms such as David Werner's (1977) Where There Is No Doctor: a village health care handbook provide useful examples of the kind of tools that could be used by community people to improve health conditions amongst the homeless in urban Canada. Werner states that his handbook has been written in the belief that.

1. Health care is not only everyone's right, but everyone's responsibility.
2. Informed self-care should be the main goal of any health program or activity.

3. Ordinary people provided with clear, simple information can prevent and treat most common health problems in their own homes - earlier, cheaper, and often better than can doctors.
4. Medical knowledge should not be the guarded secret of a select few, but should be freely shared by everyone.
5. People with little formal education can be trusted as much as those with a lot. And they are just as smart.
6. Basic health care should not be delivered but encouraged.

It is not difficult to make the leap from the rural Third World to the world of the urban homeless in Canada and to see how pertinent to the situation many of Werner's statements are.

When we look at many of the causes of ill health in the Third World, e.g. poor sanitation, inadequate housing, poor diets, exposure, an unstable lifestyle, we can not help but be struck by the similarity with the causes of ill health among the homeless. Some of the concepts used to deal with health issues in Third World situations are particularly germane to the present study.

THE PRIMARY HEALTH CARE CONCEPT

Primary Health Care is people oriented, non-professional and it depends on local human resources rather than the high technology of modern medicine. In the Third World context such an approach makes a great deal of sense when it is realized that, according to the World Health Organization, up to 80% of the population has no access to modern medical services. (See Paul Harrison (1981))

An important aspect of Primary Health Care is its special attention to those who are most at risk. In the Third World this is mostly women and children. (In urban Canada it is the homeless, men, women and children.) Primary Health Care takes the approach that those most at risk need to be educated about their position of health risk particularly with regard to the need for good nutrition practices, hygiene and sanitation.

In the 1982 edition of Ideas and Action published by the United Nations Food and Agricultural Organization an article on the experience of Primary Health Care appears, authored by Frits Muller. The article is of particular relevance to the present study, since many of the concepts it discusses are transferable to urban Canada.

HEALTH PROMOTERS

Muller describes the use of health promoters in a rural Peruvian Primary Health Care project. Health promoters are local lay people who become the ones chosen to raise awareness on and deal with local health issues. In this particular case several health promoters were chosen by the local community council. At the outset those chosen to be health promoters took short courses. These courses included practical medical work, critical discussions of health problems, administration and medical theory. The medical theory section of the course comprised the analysis of 20 of the most common local diseases, their diagnosis, treatment and prevention.

Once installed the health promoters were visited by a trained nurse every six weeks and they were all brought together on a regular basis for supportive meetings and discussions. In these meetings they would take a particular medical problem such as tuberculosis and try to understand the conditions surrounding it through role playing and 'social drama'.

For Muller community ownership of the project is vital. In this case he states: (p9)

" We insisted that the community not only chose the health promoter, but also that they were the owners of the medical equipment handled and the drugs dispensed, and that they evaluated his work at regular meetings."

Muller also describes a Primary Health Care project in an urban setting near Lima. Here a slum community of 50,000 people set up

a project complete with promoters. They eventually raised enough money to build a community health centre and installed some trained physicians in there. However, Muller insists that it is imperative that the health centre remain under community control rather than become controlled by the professional medical system.

Such community-controlled systems may well provide some possible directions for the development of more effective health care systems for the homeless in urban Canada.

There is one major concern expressed by Muller and other advocates of Third World Primary Health Care initiatives and that is the danger of setting up two parallel health systems, one for the non-poor and one for the poor. In such a situation the health care system for the poor is likely to be markedly inferior to the other system. For Muller the development of community-based health care systems is a political act that has to maintain its political function to be successful. In this way the development of the system acts to empower the poor people that use it and that deliver the service.

4. DISCUSSION OF RESULTS

In this section we will compare results from the homeless interviews and those with health care personnel. Together with the insights drawn from Third World experiences we will then draw conclusions and make recommendations.

4.1 Major Findings

The data collected through the interviews with homeless people and with health care personnel present a grim picture of the health conditions of the homeless, a picture in which day-to-day life presents a very high health risk and access to health care facilities is difficult and often unrewarding.

NON-TRANSIENT NATURE OF HOMELESS RESPONDENTS

It is important to note the non-transient nature of the homeless respondents. The mean length of time spent in Toronto was 20.25 years and 80% considered Toronto to be their home town. In this the respondents are representative of the homeless population in Toronto. Despite the fact that the popular image is one of high geographic mobility - Toronto today Vancouver tomorrow - most homeless people in urban Canada are 'geographically fixed'. We point this out, firstly because we believe the fact of 'geographical fixedness' makes it more feasible to propose stable community-based health care alternatives, and secondly because we believe the myth of high geographic mobility leads to misperceptions about the nature of modern homelessness in urban Canada. These misperceptions lead to faulty solutions such as the provision of temporary and third rate housing and temporary and third rate social and health care services.

CURRENT HOUSING SITUATION AND HEALTH

The homeless respondents registered a high rate of dissatisfaction with their current housing situation. This was particularly so with those living in hostels and rooms. There were 24 hostel residents and 15 (63%) of these felt that their housing was inadequate. Of those living in rooms, nine of the 13 (70%) considered their housing to be inadequate.

A high proportion of homeless respondents linked their housing situation directly to health problems. Hostel dwellers focussed their concerns on such issues as lack of privacy, unhygienic surroundings, overcrowding and the strict regimentation of life in the hostels and uncaring staff. These factors were all seen to be causal in bringing about health problems. The chronic lack of privacy and overcrowding is seen as leading to stress and lack of proper rest, both factors predisposing them toward mental health problems and low physical resistance to disease. The strict regimentation of life in the hostels and the presence of

uncaring staff leads to feelings of hopelessness, low self-esteem and depression.

The roomers felt that the major threats to health in their living situations were the lack of cooking facilities in rooms and the difficulty of access to washroom facilities. Lack of cooking facilities means that roomers have to 'eat out' and eating out for a homeless person means a very limited range of choice. Thus bad diets become the norm. One roomer respondent had to share one washroom with twelve other roomers. Obviously in such a situation it is difficult to maintain a reasonable level of hygiene.

The three respondents who live outdoors stressed the obvious threats to health caused by exposure to bad weather. In addition they pointed out that they too suffered from a lack of privacy, since the whole of life is lived out in public, and that potential and actual violence were a constant problem. The police were seen by this group as the source of further harassment.

HOSPITALS - USE

Hospitals are by far the most frequently used health care facilities by the homeless respondents, although there is use of public health clinics and an increasing use of Street Health. Nonetheless, the emergency department of the hospital is the homeless person's major contact with health care deliverers. St. Michael's is the most frequently used of the hospitals and Wellesley hospital is the second most frequently used. The Toronto General Hospital, The Hospital for Sick Children, Women's College and Toronto East General are other hospitals that had been used by a relatively large proportion of homeless respondents.

Homeless respondents went to these hospitals with a wide range of health conditions, most frequent among them (according to the homeless themselves) being respiratory problems, injuries, epilepsy, drug and/or alcohol related problems, foot problems, psychiatric problems. When health care personnel were asked what health problems homeless people mostly presented with, the responses were very similar i.e. drug and/or alcohol related problems, respiratory problems, foot problems, psychiatric problems. In addition health care personnel mentioned malnutrition and lice infestation as major problems.

Given that both homeless respondents and health care respondents named the same major reasons for use of hospital facilities, we believe that these reasons are likely to be the important ones. It is not difficult to understand why the health care personnel mentioned lice infestation, although the homeless respondents did not. Lice infestation is a self-esteem threatening condition and unlikely to be talked about if avoidable. Malnutrition is likely to manifest itself in a wide range of ways and it is these manifestations that the homeless respondents are likely to see as the health condition rather than malnutrition itself.

HOSPITALS - PROBLEMS WITH

When homeless respondents were asked what they disliked about hospitals, they concentrated overwhelmingly on the long waiting time that was necessary before they could be seen by health care personnel. It was this factor that respondents mentioned time and again as their major source of dissatisfaction with the hospital-based health care system.

A second problem identified was what homeless respondents perceived as the uncaring nature of the staff at hospitals. Many respondents felt that all hospital staff wanted to do was ignore them as long as possible, then when it was no longer possible to

ignore them, get rid of them as quickly as possible. They felt like 'non-people'.

Other problems mentioned frequently were general inaccessibility, i.e. hours, location, etc.; the fact that they had no OHIP coverage, and that health care staff were often too quick with prescriptions. This last complaint is particularly important when the absence of OHIP coverage is taken into account and the general lack of money for prescriptions (or anything).

Finally, a problem that was frequently mentioned by the homeless respondents was that of communication between themselves and health care personnel. Several homeless people said that they simply did not understand what the health care person was talking about. Others complained that health care staff never really listened to them, they were so keen to get rid of them. Bernstein's previously discussed notions of different languages according to different social classes are particularly germane here since, when a homeless person attempts to communicate with a health care deliverer in a hospital setting, we frequently do have cross-class communication- the homeless person being from the lower end of the working class and the health care deliverer being from the middle class.

When health care personnel were asked what they found were the major obstacles to providing adequate health care services to the homeless they stressed factors that are part of the living conditions of the homeless. Major ones were: homeless people's difficulty to comply with suggested treatment plans and the concomitant difficulty of proper follow up ; difficulty of access; the disorganized lifestyle of the homeless; lack of housing. In agreement with the homeless themselves the health care personnel found the absence of OHIP coverage and lack of money for prescriptions to be major obstacles.

Two other major obstacles highlighted by health care respondents were the inappropriately bureaucratic nature of institution-based health care service delivery systems and the lack of health care services in hostels. Recognition of these two problems by health care service providers seems to point to some support for alternative health care models.

THE MAIN HEALTH PROBLEMS

When the homeless respondents and the health care service respondents were asked to identify what they saw as the major health problems of the homeless they came up with remarkably similar answers. Both groups mentioned poor nutrition as a major problem. Poor hygiene, psychiatric problems and drug and/or alcohol related problems were mentioned by both groups, although it is interesting to note that, whereas homeless people saw psychiatric problems as major, health care personnel saw them as minor. The lack of proper rest was seen as a major problem by both groups. This relates very closely to a life lived in constantly crowded and non-private situations.

Homeless respondents said that one major concern was the fact that a particular health problem is often left unattended for too long, so that by the time help is sought what could have been a relatively minor health problem has become a serious one. Health care respondents were saying a very similar thing when they stressed the need for a higher level of self-knowledge regarding health among the homeless. With a higher level of self knowledge conditions would not be allowed to deteriorate in the same way.

Homeless respondents mentioned violence as a major health problem and, similarly, health care respondents saw 'the stress of life on the streets' as a major health problem.

Interestingly, it was the homeless respondents who mentioned lice infestation as a major problem, yet there was little mention of

this as a reason for seeking health care services. By contrast the health care personnel had mentioned lice infestations as a major reason for homeless people seeking their help and yet they did not mention it as a major health problem.

The explanation of these seeming contradictions as far as the homeless respondents are concerned is probably their reluctance to admit that they had sought help for lice infestation because of the stigma involved but their recognition that it is a problem generally among the homeless population. For the health-care personnel the explanation may lie in their seeing lice infestation as a symptom of, for example, poor hygiene, rather than a distinct problem of itself.

Foot problems and skin problems were also listed as major health problems by the homeless but not by the health care personnel and tobacco use was seen as a problem by health care personnel but not by homeless people.

Again foot and skin problems, although very real to homeless people, may be seen as manifestations of other problems such as poor nutrition or poor hygiene by health care personnel.

The matter of tobacco as a problem is interesting in terms of different class attitudes that currently prevail regarding smoking. Over the past ten or so years smoking has been increasingly rejected as a legitimate activity by the middle class. However, the anti-smoking sentiment has not, thus far, had a marked impression on the working class. This is particularly so with the lower end of the working class - a position occupied by most of the homeless. Thus smoking is still widely accepted as a legitimate activity among the homeless. It is not surprising then that the homeless respondents did not mention tobacco as a health problem whereas the largely middle class health care personnel did.

In sum, although there were some different emphases, the two respondent populations - the homeless and the health care personnel - saw the major health problems of the homeless in very similar ways.

DEALING WITH THE PROBLEMS

As with the identification of problems, there was again remarkable similarity between the two respondent groups in suggesting ways for dealing with the problems.

The two major suggestions were the provision of more community-based clinics and the provision of more affordable housing. With the latter the health care personnel suggested that part of their role be assistance in finding housing. For the homeless it was a recognition of the important role housing plays in health.

The provision of more community clinics was seen primarily by health care personnel as a system of clinics that would operate as satellites of the major institutions. Such clinics would have some day-to-day autonomy but would be responsible to the management system of the larger institutions. From the homeless respondents' perspective the community clinics would be totally autonomous and responsible to a community-based management system. Street Health was frequently used as an example.

Closely related to the suggestion for more community clinics was the suggestion to locate health care services within hostels. This suggestion was made both by homeless and health care respondents.

Both groups also called for improved access to existing health care services. For the homeless this simply meant being treated on a more equal footing with other users so that the experience of long waits and second class citizen treatment by staff would

be eliminated. For health care personnel this meant a call for 24 hour social worker staffing, more flexible hours of service, more staff and an increased advocacy role for health care staff.

While the homeless made the suggestion that more money in their pockets would make appropriate health care more available, the health care personnel tied this specifically to the notion of completely subsidized health services so that the absence of OHIP coverage would not discriminate against the homeless.

Better access to decent food was mentioned by both groups. The health care respondents suggested that this be done by making food vouchers available to the homeless and that good meals be provided in locations frequented by the homeless.

Two aspects of improved education were suggested by health care personnel. The first of these was that health care personnel be helped to understand the nature and causes of homelessness. The second was that homeless people be helped to understand more fully ways of understanding the threats to their own health that they undergo given their living conditions.

The homeless suggested that more work would help things and health care personnel suggested the provision of easily accessible showers in locations frequented by the homeless.

Finally the homeless respondents suggested the development of more drop-ins. Such drop-ins were seen as locations that would actively promote good health through the availability of good food and through health education.

The similarity in suggestions for improved health care services is again remarkable across the two respondent groups.

4.2 Conclusions

The overall conclusion that must be drawn from the foregoing is that something must be done to improve access to health care services for the homeless, to improve the delivery of health care services and to recognize that homeless people constitute a special at risk group.

CONTACT WITH THE CURRENT HEALTH CARE SYSTEM IS OFTEN HARMFUL
In his book Limits to Medicine Ivan Illich (1977) marshals considerable evidence to support the thesis that institutionalized medicine can actually do more to exacerbate health problems than to improve levels of health. Illich uses the term iatrogenesis to refer to health problems that are caused institutionalized medicine. Thomas McKeown (1976) uses historical data to show that institutionalized medicine has, in fact, had little to do with the improvement of health standards in the western industrialized world over the past century and a half. McKeown argues that overwhelmingly our improved health is due to improved living condition.

If these arguments are true in relation to the population as a whole then how much 'more true' are they in relation to powerless groups in society, specifically the homeless? We would argue that institutionalized medicine has done little to improve health for the homeless and that it is probably not capable of doing this. The following points support this argument.

Homeless respondents stated that their contacts with the institutional health system were often negative. They frequently have to wait for long periods before receiving attention and then the attention is off-handed, rude and irrelevant. Drug prescriptions for people without money or without some form of subsidy or insurance such as OHIP become a cruel joke. One of the health care respondents recognized this when he stated,

" How can I expect someone to follow instructions about soaking their feet regularly in hot water when they don't even have access to a sink?"

Many of the staff of health care institutions admitted that there is a problem in identifying with the homeless. This is not difficult to understand. Absolute poverty and daily degradation have to be experienced at first hand to be fully understood. There are those that can empathize without having 'been there', but they are few.

The 'labelling process' is particularly harmful to powerless people. Those at the bottom are more likely to believe in the truth of the label in a very profound way than are those higher up the social system. A lot of this readiness to believe comes from a lifetime of subservience and low self-esteem. Evidence that this is the case in the present study comes in the homeless respondents' willingness to believe that psychiatric problems are major health problems. Table 3.14 indicates that 20% of all problems listed by the homeless respondents were psychiatric. Health care providers relegate psychiatric problems very low on the hierarchy, even though they are the distributors of the labels. Table 3.21 shows that the health care respondents saw only 1.4% of problems they listed as psychiatric.

Both groups saw poor nutrition as being one of the major reasons for poor health and yet the institutional health care system is not at all involved in the provision of good nutrition, either directly or indirectly.

Although there are some differences in the way both respondent groups see possible solutions, the similarities are far greater. Both groups felt there was an urgent need for greater accessibility and solutions proposed leaned heavily on the

notions of community located clinics, including the idea of clinics located in hostels. For the homeless it is important that the clinics be both community located and community controlled. For health care providers community location would be linked to the notion of satellite clinic with reporting responsibility to the large health care institutions. Both groups felt that community located clinics could deal more effectively with the ever-present diet problems, foot problems and infestation problems. In addition an educational component for both service providers and service consumers could be more effectively mounted from a community-based operation.

LESSONS FROM THE THIRD WORLD

Much of the literature on Third World health issues stresses the notion of appropriate health care as a right coupled with the notion of self-care as an important goal. The approach also has a strong belief in the ability of 'ordinary' (i.e. non-professional) people to deal effectively with the most common health problems if they have access to clear and simple information. That is, basic health education is an important component of an effective lay person-based health care system. An important assumption here is that those with the knowledge be willing to give some of their monopoly control over it in the interests of better health for the powerless.

The notion of Primary Health Care with its non-professional people orientation, its emphasis on local human resources, its downplaying of 'high tech', its Health Promoters and community control provides valuable examples of what a more effective health care system for Canada's urban homeless might look like.

SEGREGATION VERSUS INTEGRATION

The concept of segregated health care services for the homeless raises some very basic issues. Intuitively many of the homeless respondents were in favour of segregated services because they

felt such services would be more in tune with their particular needs and they would also feel less threatened and more comfortable and, therefore, more able to communicate the true nature of their health problems and needs than in the larger institutional settings where they are made to feel like second class citizens, waiting in line until the 'people that really matter' have been dealt with.

Almost 50% of the health care respondents felt that segregated health care services were probably a good idea. In most cases this came out of a genuine feeling that such services would be able to better deal with the special health problems of the homeless.

The overwhelming support of the idea of community located clinics also tends toward support of a segregated system. As does the notion of mobile clinics and hostel-located clinics.

We agree that, in many ways, a separate system would likely be a better system in terms of providing more effectively for the health care needs of the homeless. And in this sense we support the thrust completely. However, we do have concerns that separate might also be separate and unequal rather than separate and equal. (The fact is that homeless people currently get unequal treatment in an integrated system.)

We feel that the way to guard against this is for community based clinics to be community controlled. That is, we would advocate that they be autonomous, managed by community boards - with a significant number of board members being homeless or ex-homeless - and politically active. By this last point we mean that boards should act as advocates on behalf of the homeless and their health needs in an active and ongoing way.

In conclusion, we believe the foregoing has demonstrated that there are some very real problems in health delivery for the homeless in Toronto and, when these are coupled with the 'high risk to health' lives that homeless people live, we have a picture of a population that is both at high risk and has only limited access to appropriate health care.

5. RECOMMENDATIONS

1. THAT THE APPROPRIATE MINISTRIES LOOK SERIOUSLY AT PROVIDING SUPPORT TO THE DEVELOPMENT OF COMMUNITY BASED, COMMUNITY MANAGED HEALTH CARE CLINICS FOR THE HOMELESS, AND THAT STREET HEALTH AND SOME OF THE THIRD WORLD, COMMUNITY-CONTROLLED EXAMPLES BE LOOKED TO AS MODELS.
2. THAT THE APPROPRIATE MINISTRY ADVISE HOSPITAL EMERGENCY SERVICES TO SEEK WAYS IN WHICH THEY CAN CUT DOWN WAITING TIME FOR HOMELESS USERS OF THE SERVICE. AND THAT THEY ENSURE HOMELESS USERS RECEIVE 'EQUAL TREATMENT'.
3. THAT THE APPROPRIATE MINISTRY REQUEST PROVIDERS OF HOSTEL SERVICE TO SERIOUSLY EXAMINE THE FEASIBILITY OF SETTING UP HEALTH CARE CLINICS WITHIN THEIR HOSTELS.
4. THAT THE APPROPRIATE MINISTRY EXAMINE SERIOUSLY THE HEALTH RELATED PROBLEMS THAT STEM FROM HOSTEL LIFE AND SEEK WAYS OF AMELIORATING THEM.
5. THAT THE APPROPRIATE MINISTRY REQUEST OPERATORS OF HOSTELS AND DROP-INS FOR THE HOMELESS TO EXAMINE THE FEASIBILITY OF DEVELOPING FOOD PROVISION PROGRAMS THAT MAY INCLUDE THE PROVISION OF WELL-BALANCED MEALS, THE DEVELOPMENT OF FOOD CO-OPERATIVES, AND THE CONDUCTING OF EDUCATIONAL PROGRAMS ON NUTRITION.

6. THAT THE MINISTRY OF HOUSING REQUIRE THOSE ORGANIZATIONS THAT RECEIVE FUNDING UNDER ITS PROGRAMS TO BUILD HOUSING FOR THE HOMELESS TO FURNISH A STATEMENT OUTLINING THE SPECIFIC AND CONCRETE WAYS IN WHICH THE PROPOSED HOUSING WILL IMPROVE THE STANDARDS OF HEALTH FOR ITS OCCUPANTS.

7. THAT THE APPROPRIATE MINISTRIES WORK WITH THE CITY OF TORONTO DEPARTMENT OF PUBLIC HEALTH TO DEVELOP AN EDUCATIONAL PROGRAM ON THE NATURE AND CAUSES OF HOMELESSNESS AND ITS HEALTH IMPLICATIONS AND AN EXAMINATION OF THE WAYS IN WHICH THE LANGUAGE USE OF DIFFERENT SOCIO-ECONOMIC CLASSES CAN CAUSE COMMUNICATION BARRIERS, AND THAT SUCH A PROGRAM BE COMPULSORY FOR THOSE HEALTH CARE STAFF INVOLVED IN WORK WITH THE HOMELESS.

8. THAT THE APPROPRIATE MINISTRIES WORK WITH THE CITY OF TORONTO DEPARTMENT OF PUBLIC HEALTH TO DEVELOP AN EDUCATIONAL PROGRAM ON THE PARTICULAR HEALTH RISKS FACED BY THE HOMELESS AND ON HOW TO MOST EFFECTIVELY AVOID THESE AND THAT SUCH A PROGRAM BE MADE AVAILABLE TO THE HOMELESS WHERE THEY ARE - E.G. IN DROP INS, HOSTELS, IN PARKS, ETC.

9. THAT AN INTER-MINISTRY FUND BE SET UP BY THE MINISTRIES OF HEALTH, HOUSING AND COMMUNITY AND SOCIAL SERVICES TO HELP ENCOURAGE CREATIVE INITIATIVES FOR GRASS-ROOTS GROUPS THAT WILL HELP TOWARD THE IMPROVEMENT OF HEALTH LEVELS FOR THE HOMELESS. SUCH A FUND SHOULD SUPPORT PROJECTS FOR A PERIOD OF THREE YEARS, AFTER WHICH, IF THE PROJECT IS CONSIDERED SUCCESSFUL, IT WOULD BE SUPPORTED BY THE APPROPRIATE MINISTRY.

10. THAT POLICY AND PLANNING ARMS OF MINISTRIES INVOLVED IN PROGRAMS THAT AFFECT THE HOMELESS SHOULD INVOLVE THE HOMELESS DIRECTLY IN THE DEVELOPMENT OF POLICIES AND PLANS THAT IMPINGE ON THOSE PROGRAMS.

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